COUNTY OF SAN DIEGO

Department of Environmental Health
Community Health Division
Radiological Health Program
P.O. BOX 129261, SAN DIEGO, CA 92112-9261
(619) 338-2969 FAX (619) 338-2592

KIVA #: _____

PLAN CHECK #: _____

ACTIVITY #: _____

FEE AMOUNT $: _____

PAYMENT TYPE:

☐ **CASH** ☐ **CHECK** _____ **Check Number**

RADIATION SHIELDING PLAN CHECK APPLICATION

Plans submitted by: _____ Phone #: ( ) _____

Facility Name/ Owner's Name: _____ Phone #: ( ) _____

Job Site Address: _____ Zip: _____

Mailing Address, if different: _____ Zip: _____

X-RAY MACHINE INFORMATION

# of Rooms	Manufacturer	Model/Type
_____	_____	_____
_____	_____	_____

OWNER/REPRESENTATIVE DECLARATION: I understand that the fee paid is based on my declaration of the radiation shielding classification. If the declaration is incorrect, I understand that this application will not be approved until the appropriate fee is paid.

Signature: _____ **Title:** _____ **Date:** _____/_____/_____

This space for Office Use Only:

CLASSIFICATION		NO. OF ROOMS	FEES FY 07-08 ($)	TOTAL
DENTAL, MEDICAL, or INDUSTRIAL	FIRST TWO ROOMS (6CRAD-----O)		80.00	
	EACH ADDT'L ROOM UP TO 6 (6CRAD----O)		42.00 EACH	
	MORE THAN 6 ROOMS (6CRADHR--O)		IN ADDITION TO $248 BASE FEE, HOURLY FEE BASED ON REVIEW TIME	